

Echoes from the 40th Annual San Antonio Breast Cancer Symposium, 2017

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ABSTRACT

The Annual San Antonio Symposium was held on 5-9, December, 2017 in San Antonio, Texas, USA (1). As expected, many new studies were presented for the first time at the sessions. The unofficial opening lecture in my point of view was given on locoregional recurrence by Monica Morrow from MSKCC, New York. As always, Morrow's lecture on "Challenges in the surgical management of locoregional recurrence" attracted great interest. The other prominent conferences were given on "Individualizing Management of the Axillary Nodes" by Tari A. King from Dana-Farber Cancer Institute and on "Appropriate margins for breast conserving surgery in patients with early stage breast cancer: A meta-analysis" by Shah C from Cleveland Clinic.

Keywords: Breast cancer, Breast Cancer Symposium, San Antonio

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Morrow reported that changing treatment landscape had raised new questions on axillary management, on initial sentinel lymph node (SN) biopsy and repeat lumpectomy. The important remarks that I selected from her lecture are as follows: Metastatic work up is essential prior to any local therapy for locoregional recurrence (LRR); because, historically ~50% of LRR was accompanied by distant metastases. Axillary dissection is an appropriate approach for axillary recurrence after SN biopsy. Reoperative SN biopsy after local recurrence is feasible, accurate and provides useful information. A SN can be identified in the majority of the patients who had initial SN biopsy (81%), and in about 50% of those with axillary dissection. Aberrant drainage is common after SN or axillary dissection and has implications for mapping. Extra-axillary or aberrant lymphatic drainage is uncommon in untreated axilla. However, in patients with ipsilateral breast recurrence (IBTR) after a breast conserving surgery (BCS) and SN biopsy or axillary dissection, aberrant drainage is likely in one third of patients. Because prior axillary surgery increases drainage to contralateral axilla, this is not necessarily a metastatic disease. In patients who had contralateral axillary metastases identified with ipsilateral local recurrence, Morrow suggested to do metastatic work-up and to exclude contralateral breast primarily with mammography and magnetic resonance imaging, and if local recurrence was operable and non-locally advanced, to perform axillary dissection. Combined radioactive colloid and blue dye is recommended for reoperative SN biopsy, because identification of extra-axillary SN is uncommon with intradermal or subareolar injection. She suggests peritumoral injection is optimal in reoperative setting. Under the heading of 'Management of IBTR after BCS: Is lumpectomy alone appropriate?', the indications for repeat lumpectomy alone were suggested as follows: disease meeting criteria for no radiotherapy after primary surgery (that is, low risk group); age >70 years, T1N0 ER+ Her2-, Grade 1, 2 DCIS ≤1.5 cm, disease suggestive of second primary tumor with long disease-free interval, in separate quadrant, and patients with severe morbidity. Morrow concluded that better data were needed to define optimal management of LRR.

Tari King reported that the quest for optimal regional treatment is continuing, and the goal of balancing the risks and benefits of treatment options is to minimize morbidity of local regional treatment without compromising the outcome. Here are the remarks from her lecture: SN after neoadjuvant chemotherapy (NAK) in T1, 2, cN0-cN1 patients decreases axillary dissection significantly due to the decrease in % of node positive axilla. Benefits of avoiding axillary dissection were manifested with lower rates of lymphedema (11-14% for axillary dissection vs. 3-8% with SN). Rationale for NAK in cN+ patients was that nodal pCR rates were 38-49%. Nodal pCR rates were 21% for ER+/Her2-, 47% for ER-/Her2-, 70% for ER+/Her2+, and 97% for ER-/Her2-, respectively. There is no role for nomograms to predict the likelihood of additional axillary metastases or PET scans to look for additional metastases. In response to "When can nodal staging be omitted?", from 'CALGB randomized trial of the omission of radiotherapy', patients with age ≥70 years, T1N0, ER+, patients who had BCS and tamoxifen treatment were suggested as candidates for omission of axillary staging. Ten-year rate of axillary failure for these patients (no: 392) was 1.5%. Tari King concluded under the title of "Where will we go from here" that "there was no improvement on survival with axillary dissection", "Increasing role of biology vs. anatomy in decision making for systemic therapy", and "Growing interest to omit axillary staging".

Shah reported the results of the new meta-analysis on surgical margin after BCS. He explained the new methods used in the new analysis and compared the findings with the previous meta-analysis by Houssami et al. who concluded that wider than negative margins were unlikely to have substantial local control benefit. Current SS-ASTRO Guidelines for invasive breast cancers with lumpectomy recommends no tumor on ink as the appropriate margin as suggested by the previous meta-analysis of Houssami et al. Shah et al. query for this recommendation and ask the question: “Is this correct?” Instead of two methods used in the previous meta-analysis, they used three methods for margin evaluation. In the third method, i.e., the new one, the margin ranges which were ‘no tumor on ink’ (indicated as negative margin, 0-2 mm, 2-5 mm, and >5 mm) were used for the analysis. In the new meta-analysis, there were 55,302 patients from 38 studies and >20,000 additional patients with BCS. In multivariate analysis, the margin width was significantly associated with decreased local recurrence when using margin ranges. Data suggests that having a margin width beyond ‘no tumor on ink’ may further reduce rate of local recurrence. Shah et al. concluded that the new questions were as follows: “Should we achieve a 1-2 mm margin as compared with no tumor on ink?”, “What is the local control benefit vs. morbidity, time, cost?”, and “Which patients with ‘no tumor on ink’ need more surgery?”

Among more than 1400 poster presentations, there were three poster presentations from Turkey. Two of the posters were presented by Guldeniz Karadeniz Çakmak from Bülent Ecevit University, School of Medicine, Zonguldak and the third was presented by Bekir Kuru from Ondokuz Mayıs University, School of Medicine, Samsun.

Karadeniz Çakmak et al. (2) reported on the first poster that in 194 patients treated with breast conserving surgery after neoadjuvant chemotherapy, continuous intraoperative ultrasound with specimen sonography was an invaluable and effective modality to achieve negative surgical margins. Karadeniz Çakmak et al. (3) concluded on the sec-

ond poster that a study performed on 69 patients showed that surgeon performed axillary ultrasound was a beneficial tool with the potential of accurate prediction of axillary disease in up to 78% of patients after neoadjuvant chemotherapy.

Kuru et al. (4) studied 440 patients with ductal carcinoma in situ (DCIS) associated with invasive breast carcinoma (IBC) among 628 T1-2 IBC patients and concluded that ‘no ink on tumour’ was an adequate margin for DCIS associated with IBC in patients who underwent breast conserving therapy and was not associated with increased ipsilateral breast cancer recurrence.

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